

**STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF LIFE AND HEALTH
MANAGED CARE BUREAU**

**DENTAL PLAN ORGANIZATION (DPO)
CERTIFICATE OF AUTHORITY
RENEWAL APPLICATION**

State of _____
County of _____

The undersigned, being duly sworn according to law upon his/her oath deposes and says:

I, _____ in my capacity as
(Affiant's full printed name-no initials)
_____, on behalf of
(Affiant's Title)
_____, which is located at
(Name of dental plan organization)

(Street and City where dental plan organization is located)

in New Jersey, do hereby make application for the renewal of the Certificate of Authority of the above-named dental plan organization, which Certificate of Authority shall otherwise expire on _____.
(Expiration date and year)

I do hereby certify on this _____ day of _____,
_____, under penalty of perjury that I am a principal officer of the above-
(Year)
named dental plan organization, and that all statements made herein and in the Certificate of Authority Renewal Request Form attached hereto and incorporated herein are true and correct to the best of my knowledge and belief.

(Signature of Affiant)

Subscribed and duly sworn before me, the undersigned authority, on this _____ day of _____,
(Year)

(Seal)

(Notary Public)
My Commission Expires _____

DENTAL PLAN ORGANIZATION
CERTIFICATE OF AUTHORITY RENEWAL REQUEST FORM

Full Name and Address of Dental Plan Organization

Provide relevant information to each numbered item below. If an item is not applicable, mark it as nonapplicable or NA. Failure to respond to all items may delay the review process. If you need more space than is provided to answer any item, attach additional pages to complete the answer. Please number answers in accordance with the item number. Submit all documents required to be attached to this form with this form, indicating the item number to which the document is responsive. When completed, and no later than 60 days prior to the date of expiration of the current Certificate of Authority, submit this form and all attachments, the Certificate of Authority Renewal Affidavit and the required renewal fee to:

Chief, Managed Care Bureau
Office of Life and Health
Department of Banking and Insurance
20 West State Street
P. O. Box 325
Trenton, NJ 08625-0325

1. List, in reverse chronological order, any changes which have been made in the past three (3) years to the articles of incorporation, articles of association, partnership agreement, shareholder agreement, bylaws and other documents regulating the conduct or internal affairs of the DPO. Specify the date of change and document changed, date submitted to the Department and date of the Department's approval, if applicable.

2. List any new officers, partners or members of the DPO's Board of Directors, Board of Trustees, Executive Committee or other governing board or committee, who have been hired, elected or appointed within the past three (3) years. (Provide full name, date of hire, election or appointment; and date of submission of Biographical Affidavit (NAIC form to the Department of Banking and Insurance.)

If Biographical Affidavit has not been submitted to the Department so indicate and submit with this renewal request form. Please use NAIC format for Biographical Affidavit.

3. Have any professional, occupational or vocational licenses of any officer, partner or members of the DPO's Board of Directors, Board of Trustees, Executive Committee or other governing board or committee been amended or, terminated within the past three (3) years?

YES _____ NO _____

If yes, attach a list indicating name, position, type of license, date of amendment or termination and an explanation.

4. Has any officer, partner or member of the DPO's Board of Directors, Board of Trustees, Executive Committee or other governing board or committee or any other person responsible for conducting the affairs of the DPO:

a. Been indicted or convicted of a crime, misdemeanor or disorderly person offense in this State, other state, or by the federal government?

YES _____ NO _____

If yes, attach a certified copy of the indictment or judgment of conviction, which may be obtained from the clerk of the court where the conviction was entered.

b. Had any business or professional license been suspended or revoked?

YES _____ NO _____

If yes, attach a copy of the order of suspension or revocation from the professional or governmental authority.

c. Filed for bankruptcy, been declared bankrupt or made an assignment of creditors?

YES _____ NO _____

If yes, attach a copy of the bankruptcy petition, complaint in bankruptcy, or complaint in action for assignment to creditors.

5. Have any changes been made or any new contracts or agreements been made with any consultant, finder or business manager within the past three (3) years?

YES _____ NO _____

If yes, attach a list including a brief description of the change, date of submission of and date of approval by the Department.

6. Have any changes been made to provider contracts in the past three (3) years?

YES _____ NO _____

If yes, attach a list including brief description of the change, date of submission to and date of approval by the Department.

7. In reverse chronological order, specify the number of "full-time equivalent dentists", as defined at N.J.A.C. 11:10-1.3, under contract with the DPO as of the date of the submission of this form and December 31 of the two immediately preceding years:

Current _____:

12/31/ _____:

12/31/ _____:

8. Attach a list of any changes which have been made to the form of any group or non-group contract or evidence of coverage within the past three (3) years, specifying the type of form, form number, date submitted to the Department and date of Department approval.

9. List the number of group and non-group contracts in force and the group and non-group enrollees' count as of the date of this form and at December 31 of the prior two (2) years.

	Group Contracts	Group Employees	Group Dependents	Non Group Contracts	Non Group Subscribers	Non Group Dependents
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Current _____:

12/31/ _____:

12/31/ _____:

10. List in reverse chronological order how many types of benefit plans currently are being offered, and the number available on December 31 of the two immediately preceding years:

Current _____:

12/31/ _____:

12/31/ _____:

11. Give a brief description of any changes made to the schedule of charges within the past three- (3) years listing dates of submission to the Department.

16. List the total surplus, as of the quarter ending on or before the date of this form and December 31 of the prior two years.

	<u>Total Surplus</u>
Qtr Ending _____:	_____
12/31/____:	_____
12/31/____:	_____

17. In compliance with N.J.A.C. 11:10-1.8, the general surplus, as of the quarter ending on or prior to the date of this form, has been maintained as follows:

<u>Balance Sheet Item</u>	<u>Amount</u>
_____	_____
_____	_____
<u>Total</u>	_____

18. In compliance with N.J.S.A. 17:48D-7, the special contingent surplus, as of the quarter ending on or prior to the date of this form, has been maintained as follows:

<u>Balance Sheet Item</u>	<u>Amount</u>
_____	_____
_____	_____
<u>Total</u>	_____

19. In compliance with N.J.A.C.11: 10-1.12 (c) 2., the specialty pool surplus, as of the quarter ending on or before the date of this submission and December 31 of the prior two years.

	<u>TOTAL SPECIALTY POOL</u>
Qtr Ending:_____	_____
12/31/__: _____	_____
12/31/__: _____	_____

20. Pursuant to N.J.A.C. 11:10-2.5(a), have you received written verification from each employer or other organizations as defined by N.J.A.C. 11:10-2.2 that they are in compliance with N.J.A.C. 11:10-2.1 and N.J.S.A. 17:48D-9.1 and 9.2?

YES

NO

If no, explain the actions you will take to acquire such verifications.

(Date)

(Signature)

(Type Name)

(Title)